Welcome

Patient Information

Date_______________________________________

SS#_______________________________________

Patient Name ________________________________

Address_____________________________________

City____

State________________ ZIP_________________

Email_______________________________________

Birthday_________________ Age ________________

SEX: __M __F

Phone #'s Home:__________ Cell:________________

In Case Of Emergency

Name: ________________ Contact #__________

Relationship to Patient _______________________

Dental Insurance

Employer__________________ Work#_____________

Insurance Co.____________________

Policy Holder Name ___________________________

Group #_________________________

D.O.B __________________________

SS#____________________________

Secondary Dental Ins.

Employer__________________ Work#_____________

Insurance Co.____________________

Policy Holder Name ___________________________

Group #_________________________

D.O.B __________________________

SS#____________________________

Referred by __________________________ **General Dentist**___________________________

Chief Dental Complaint/Concerns ____

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Assignment and Release : I Certify that I, and/or my dependent(s), have insurance coverage and assign directly to the Doctors at South Shore Long Island Periodontics and Implantology all insurance benefits, if any, otherwise payable to me for service rendered, I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submission. The Doctors may use my health care information and may disclose such information to my insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature (patient, Guardian or responsible person) ________________________Date:__________

Health History

Have you ever had any of the following diseases or medical problems??
Please circle Yes or No

Y N Asthma
Y N COPD
Y N Abnormal Bleeding/Hemophilia
Y N Anemia
Y N Blood Transfusion
Y N Circulatory problems
Y N Sickle cell Disease /Traits
Y N AIDS or HIV infection
Y N Diabetes
Y N Cholesterol
Y N High Blood Pressure
Y N Heart Disease
Y N Artificial Joint/ Valves/Plates/Pins/Screws
Y N Angina/Chest Pain
Y N Heart Attack/Heart Surgery
Y N Pacemaker/Defibrillator
Y N Congenital Heart Defect
Y N Mitral Valve Prolapse/Heart Murmur
Y N Rheumatic /Scarlet Fever
Y N Stroke
Y N Kidney Disease
Y N Liver Disease

Y N Hepatitis/Jaundice
Y N Alcohol/Drug Abuse
Y N Lupus
Y N Autoimmune disorders
Y N Osteoporosis
Y N Arthritis
Y N Neurological Disorders
Y N Cancer / Chemotherapy
Y N Radiation Treatment
Y N Psychiatric Treatment
Y N Seizures
Y N STD
Y N Epilepsy/ Convulsions
Y N Fainting Spells
Y N Sinus Problems
Y N Glaucoma
Y N Thyroid Disease
Y N Tuberculosis (TB)
Y N Herpes/Fever Blisters
Y N Ulcers/stomach troubles
Y N Parkinson's Disease
Y N Alzheimer's Disease/Dementia

Health History

Medications

List any medications you are currently taking:

____

____

____

Pharmacy Name: ______________________

Address: ______________________________

Phone (___) ___________________________

Are you allergic to any of the following :

Y N Aspirin

Y N Codeine

Y N Local Anesthetics

Y N Jewelry/ Metals

Y N Latex

Y N Iodine

Y N Erythromycin

Y N Penicillin

Y N Tetracycline

Y N Other antibiotics

Y N Sedatives

Y N Food Allergies

Please list any other drugs/ medications that you are allergic to: ___________________________

____

Physician's Name: _______________ **Phone #**:____________ **date of last Visit**: ________

Has there been any changes in your general health in the past year? **Y N**

____

Do you smoke or use tobacco in any form? **Y N**

Have you had any serious illness, operations or been hospitalized in the past 5 years? **Y N**

____

Are you taking medications for osteoporosis? **Y N**
(Ex: *Fosamax*, *Actonel*, *Boniva*, *Reclast*, *Prolia*, *Xgeva*, etc.)____

Are you taking any blood thinning medications? **Y N**
(Ex: *Warfarin/Coumadin*, *Aspirin*, *Pradaxa*, *Xarelto*, *Plavix*, *Effient*, *Brilinta*, *Aggrenox*, *Apixaban*, etc.)___________

Are you currently taking birth control pills? Are you Pregnant? **Y N** if yes, Week #________

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental service that I may need during diagnosis and treatment, with my informed consent. The office reserves the right to verify the credit status of potential patients and /or parents prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Patient/Guardian Signature____ Date ___________________